Written evidence submitted by the Centre for Mental Health (CSR0028)

Introduction

Centre for Mental Health is an independent charity that seeks a fairer chance in life for people with mental health problems through research, development and training. Our work includes significant research into the economics of mental health and ways in which health and care services can become more effective, efficient and sustainable. Our evidence draws on that research in connection with the Committee’s key lines of inquiry.

Key points

There is considerable scope for the NHS as a whole, and the wider health economy, to be more effective, efficient and sustainable long-term through targeted reinvestment in effective mental health interventions.

Savings linked to service improvements can be achieved in a number of ways, in particular by:

- Refocusing on earlier intervention, including in perinatal and children’s mental health care
- Integrating mental and physical health care for the 4.6 million people in England with co-occurring conditions
- Improving the care of people with severe mental illnesses such as psychosis.

Cuts to non-NHS health spending risk undermining existing investment in cost-effective early interventions such as parenting programmes and suicide prevention activities.

Progress to date in achieving parity of esteem for mental health services has been patchy. There has been significant action nationally, in some local areas and in some types of service (eg crisis care and improving access to psychological therapies), but not universally.

Evidence about the funding of mental health care is unclear, especially for children and young people. The absence of a clear national or local picture makes it more difficult to gauge where progress is being made.

1 Achieving service transformation

1.1 Research by Centre for Mental Health and other organisations has demonstrated the scope for making better use of public money by reinvesting in improved mental health support.

1.2 The Centre was commissioned by NHS England’s Mental Health Taskforce to explore priority areas for investment (Parsonage et al forthcoming). We identified nine areas (under three major headings) where investment in proven interventions that are currently not provided at a sufficient scale could generate significant improvements in outcomes and represent good value for money:

Prevention and early intervention
• Identification and treatment of anxiety and depression for women during pregnancy and after childbirth

1.3 Perinatal mental illness (including depression, anxiety and psychosis) carry an economic and social cost of £8.1 billion for every one-year birth cohort in the UK (Bauer et al 2014). Only a minority of women with common mental health problems during and after pregnancy receive effective support through a combination of under-identification of need and under-provision of NICE recommended interventions (Khan 2015). We calculated that implementing NICE guidelines for perinatal mental health care across England would cost £290 million a year on top of existing provision (Bauer et al 2014).

• Treatment of conduct disorder in primary school age children

1.4 An estimated 5% of children have behavioural problems sufficiently severe and enduring to justify a clinical diagnosis of conduct disorder. A further 15% of children have moderate behavioural problems. Children with behavioural problems from a young age experience the poorest life chances and face a high risk of all adult mental illnesses and poor physical health. Evidence-based group parenting programmes that help families to manage behavioural problems in children under age 10 represent excellent value for money: the cost an average of £1,270 per child compared to a £275,000 lifetime cost of conduct disorder (Parsonage et al 2014). Current provision of evidence-based programmes is patchy: most families do not get help even though three-quarters of parents whose children have behavioural problems seek support.

• Early Intervention in Psychosis

1.5 Early Intervention in Psychosis (EIP) services offer young people intensive support during their first episode of psychotic illness. They have been demonstrated to achieve better outcomes both short- and long-term and to save £15 for every £1 invested (Knapp et al 2014).

*Integrated mental and physical health care*

• Liaison psychiatry services in acute hospitals

1.6 Liaison psychiatry services offer patients throughout a general hospital speedy access to mental health support. As well as working with A&E departments they are available to all wards and as well as assessing and treating patients they educate other hospital staff in mental health. Centre for Mental Health research identified that a liaison psychiatry service at a ‘typical’ hospital could save £5 million a year by reducing numbers of admissions and lengths of stay, especially among older patients (Parsonage et al 2012).

• Integrated care for people with long-term physical and mental health conditions

1.7 One-third of people with a long-term physical condition also has a mental health problem. This co-morbidity is associated with poorer outcomes and higher costs, adding 45% to the cost of health care for their physical illness. This amounts to an additional cost to the NHS of £10 billion a year (Naylor et al 2012). Collaborative care, including active case management and proactive mental health support, for people with co-morbid conditions has been shown in small-scale trials to improve outcomes and is likely to reduce costs over time.
• Improved management of people with medically unexplained symptoms and related complex needs

1.8 Medically unexplained symptoms are physical symptoms that do not have any readily identifiable cause or are disproportionate to the severity of any underlying medical illness. They are common and distressing and cost the NHS £3 billion a year. A psychological therapy service working with GPs in Hackney, evaluated by the Centre, was found to produce significant improvements in health among patients with medically unexplained symptoms and complex needs while also reducing GP visits, A&E attendances and outpatient appointments (Parsonage et al 2014b).

**Improved services for people with a severe mental illness**

• Supported employment services for people with severe mental illnesses

1.9 People with severe and enduring mental health problems have a very low rate of employment (under 10%) yet at least half would like the opportunity to work. The most effective approach to supported employment, Individual Placement and Support (IPS), can help 50-60% of participants into paid work, many of whom sustain employment and enjoy better health as a consequence (Centre for Mental Health 2013). There is further potential for the principles of IPS to be adapted for people with common mental health problems.

• Community-based alternatives to acute inpatient care for people in a crisis

1.10 Crisis resolution and home treatment (CRHT) teams provide support to people with severe mental health problems in a crisis, where possible offering intensive support at home instead of admitting the person to hospital. There is evidence that where CRHT teams are implemented faithfully to the model they save £1.68 for every £1 invested (Knapp et al 2014).

• Interventions to improve the physical health of people with severe mental illness

1.11 People with schizophrenia have a life expectancy that is 15-20 years shorter than average in the UK. Most of this excess mortality is due to poor physical health, one of the causes of which is a very high rate of smoking. There is strong evidence that smoking cessation treatment is just as effective for people with a severe mental illness as the rest of the population (Action on Smoking and Health 2015).

2 The effect of cuts to non-NHS England health budgets

2.1 Cutting public health budgets risks undermining the already low levels of investment in public mental health activity in local councils. A survey by Mind (2015) recently found that only 1% of public health budgets are devoted to mental health promotion and prevention despite growing evidence of the benefits of some interventions.

2.2 Despite the low level of spending on public mental health, local authorities are supporting a broad range of activities, including innovative community-facing suicide prevention programmes (Moulin 2015), parenting programmes and action to prevent loneliness and isolation in later life.
2.3 Our research has shown that evidence-based approaches to preventing severe behavioural problems in children represent excellent value for money (Parsonage et al 2014). Group parenting programmes that help parents to manage their children’s behaviour can help to prevent or mitigate severe behavioural problems as well as improve relationships and reduce family stress. Yet funding for these programmes tends to be tenuous, short-term and pieced together from multiple budgets (Brown et al 2012).

2.4 We are very concerned that these programmes will be put under additional pressure following cuts to non-NHS health budgets. This will very quickly create false economies and over time increase the costs of more expensive interventions across numerous public sector budgets.

3 Progress on achieving parity of esteem through funding for mental health services

3.1 There is mixed evidence about the progress that has been made to date in achieving parity of esteem for mental health services. The discontinuation in 2011/12 of the National Survey of Investment in adult mental health services removed a vital source of information about spending on specialist mental health services. Since that time we have had to rely on sporadic Freedom of Information requests and Parliamentary Questions to elicit accurate information on spending.

3.2 Accurate data on spending on children’s mental health care is more difficult to find. CAMHS are funded from three separate sources (schools, CCGs, local authorities and NHS England) with wide variations in who commissions what across the country.

3.3 Information we have been able to gather would suggest that mental health services have been under considerable pressure and over the last five years have faced real terms reductions in funding. It is as yet unclear whether CCGs across England met the requirement in the 2015/16 Planning Guidance from NHS England to give real terms spending increases to mental health services.

3.4 The Spending Review pledged an increase of £600 million in mental health spending over the next five years. The Budget of March 2015, meanwhile, pledged to provide an extra £1.25bn over five years on children’s mental health services (ie around £250m a year).

3.5 The Prime Minister’s announcement in January of further investment in perinatal mental health care, crisis services, liaison psychiatry and eating disorder treatment provided some detail about priority areas for investment but it remains unclear how much will be available in each year and how much of this will be recurrent.

3.6 These investments are welcome but they represent only a fraction of what would be required to bring about parity for mental health care. Improving perinatal mental health services so that all areas meet NICE guidelines would cost £280 million a year on top of existing expenditure. It is therefore vital that they are used to bring about transformational change in the NHS and its partners, bringing in further investment to build and sustain service developments.
References

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